Next Steps for Indiana

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Creating an Array of Evidence- Based Practices

Training Objectives

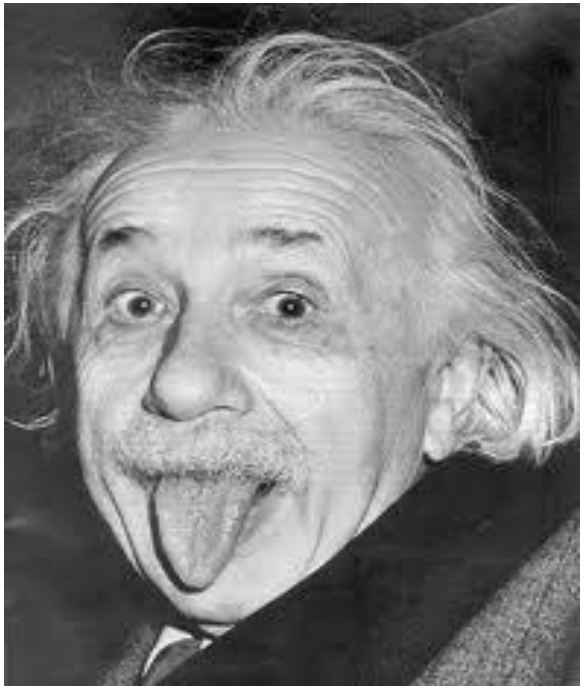
- Define evidence-based practice and discuss the applicability of evidence-based programs to DCS populations
- Provide examples of relevant evidence-based practices
- Discuss challenges to successful implementation and strategies to overcome them
- Outline DCS initiative to establish a continuum of evidence based services

Where we stand: Current Trends in Indiana

- Youth and families involved with DCS have more complex mental health needs than in the past
- Indiana providers underutilize evidence-based treatments
- Very few providers assess for trauma and/or provide evidence-based treatment for trauma (most DCS youth have experienced multiple traumas)
- Residential providers serve youth with the most significant mental health needs but typically focus on behavioral/ compliance issues (as opposed to trauma-related issues)
- Psychotropic medications are utilized at higher rates among DCS-involved youth – especially those youth placed outside the home – than among the general population

A word about the status quo…..

Insanity: doing the same thing over and over again and expecting different results.
Albert Einstein

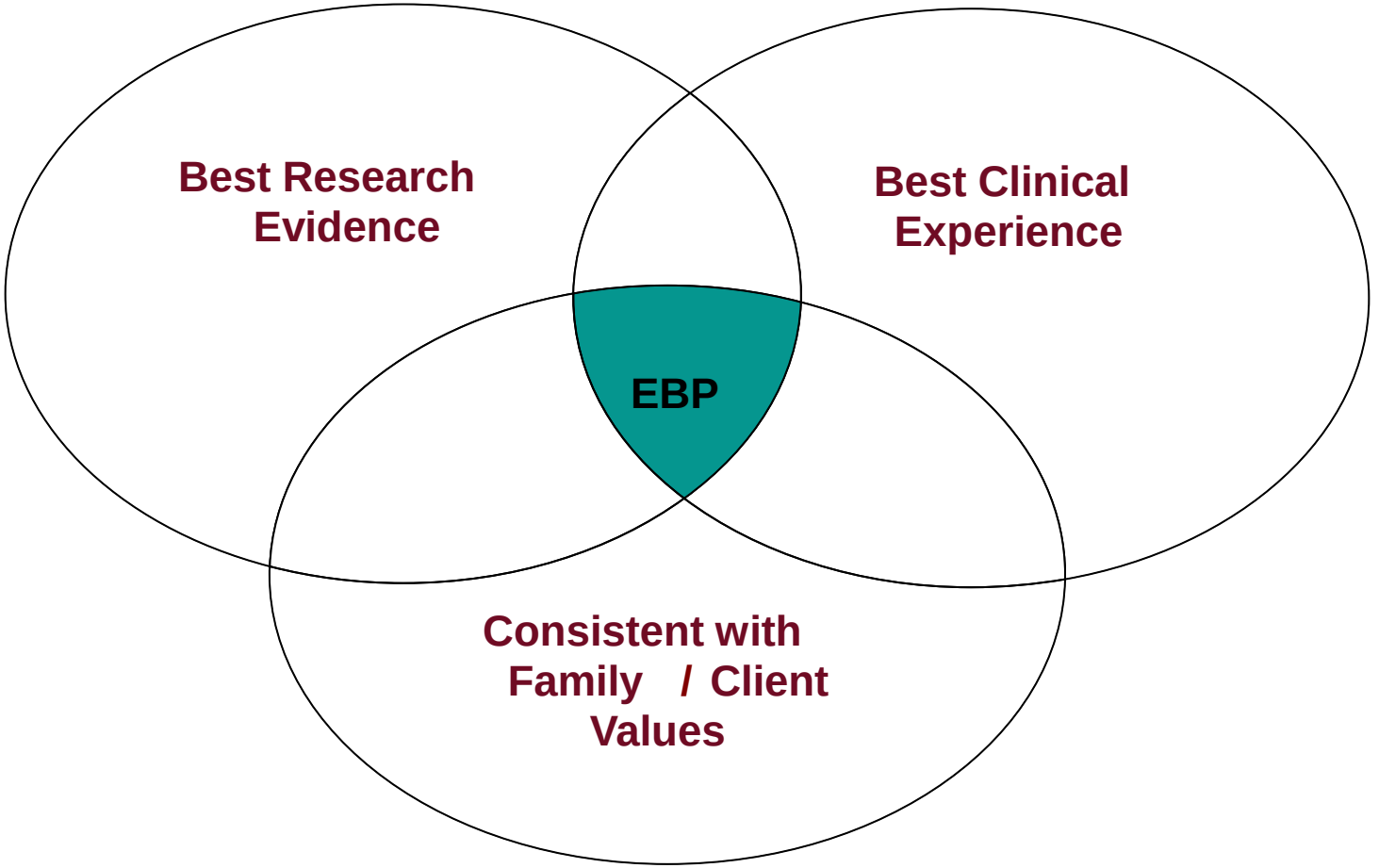


Evidence-Based Practice Defined

"Evidence-based practices are interventions for which there is consistent scientific evidence showing that they improve client outcomes."

Drake et. al. (2001)

Evidence Based?


Best Research Evidence
Best Clinical Experience
EBP
Consistent with Family / Client Values

What makes a program evidence-based?

To qualify as "evidence-based," programs must be:

- Based on a solid scientific theoretical foundation
- Carefully implemented and evaluated using research methods (random assignment, control groups, etc.)
- Replicated and evaluated in a variety of settings and with a range of populations (Treatment Manual)
- Subjected to critical review with findings published in peer-reviewed journals
- "Certified" as evidence-based by a federal agency or a respected research organization (e.g., APA, SAMHSA, etc.)

Things to Consider

- Ineffective vs. not adequately studied?
- Fidelity vs. discretion?
- Science vs. art?
- My “effective” vs. your “effective”

Levels of Evidence

1. ***Effective*** – improves child/family outcomes, based on scientific research with independent replication (endorsed by Agency for Health Care Research, SAMHSA, etc.)
2. ***Promising Practices*** **-** programs that have considerable evidence or expert consensus and which show promise in improving client outcomes, but which are not yet proven by the highest or strongest scientific evidence.
3. ***Emerging Practices*** – new, clearly defined innovations with practice guidelines that address critical needs of a particular program, population or system, but do not yet have scientific evidence or broad consensus support.
4. ***Not Effective*** – evidence suggests that the practice is ineffective, or even harmful.
5. ***Not Evaluated*** – no evidence one way or another

Why Evidence-Based Practice?

vs.

Would you want your mechanic to use "evidence-based" practices?

What about your dentist?

Why not your mental health provider?

Bottom line: If we aren't using evidence-based practices, what are we using?

What are the benefits to DCS?

- Evidence-based programs are more likely to produce positive outcomes for DCS youth and families
- National data are available for many evidence-based programs to estimate cost effectiveness
- Efficiency – evidence-based programs can be implemented without reinventing the wheel
- Standardization – evidence-based programs can be replicated across multiple locations
- Evidence-based programs create a "common language" between providers and FCMs

Example Evidence-Based Programs

- Functional Family Therapy (FFT)
- Multisystemic Therapy (MST)
- Parent-Child Interaction Therapy (PCIT)
- Multidimensional Treatment Foster Care
- The Incredible Years
- MATRIX
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Barriers to Implementation

- Cost – who pays for implementation, fidelity costs, etc.?
- Training – who, where, how much?
- Threat to existing organizational structure and relationships – resistance
- Uncertainty as to whether these programs generalize to diverse populations
- Staff turnover
- Provider culture shift
- "Flavor of the month"

Additional Provider Concerns

- Evidence-based programs devalue professional expertise
- Evidence-based programs are not consumer-driven, individualized, strengths-based, etc.
- Evidence-based programs are too prescribed, manualized and inflexible
- We already have programs that work (or "we're already doing that")
- Adopting evidence-based programs may limit consumer/provider choice

Implementing Evidence-Based Practice

Key Implementation Issues

"Begin with the end in mind."
Stephen Covey

- Identify target population
- Identify desired outcomes
- Identify best EBP
- Work "backwards"

Implementation Issues (Cont.)

Must address a number of practical issue:

- Funding – implementation, training, fidelity, etc.
- Referrals – where will they come from, volume, etc.
- Staffing – must assess current competence, credentials, availability, etc.
- Training – who will provide, will there be ongoing need for consultation, etc.
- Administrative oversight – who will be accountable, performance improvement, etc.

Implementation Issues (Cont.)

The problem of program "drift"

- Insufficient training or supervision
- Practitioners have multiple or competing demands
- Little or no attention to fidelity monitoring
- Failure to adhere to caseload standards
- Key staff turnover

Implementation Issues (Cont.)

Keys to making evidence-based practice work:

- Get leadership buy in from the beginning
- Focus on fidelity from the outset – don't assume that training alone is sufficient
- Set reasonable time frames for implementation
- Assess staff competency and fidelity
- Integrate new initiatives into agency performance improvement plans – measure fidelity measures and program outcomes regularly

DCS Target Areas for Evidence-Based Practice

- Treatment for Trauma
- Family Stabilization
- Family-Focused Programs
- Programs for 0-3
- Substance Abuse
- Psychotropic Medications

Evidence Based?

EBP for Trauma Treatment

- Trauma-Focused Cognitive Behavioral Therapy
- Child-Parent Psychotherapy (0-6)
- Integrative Treatment for Complex Trauma
- Dialectical Behavioral Therapy (Borderline teens with trauma histories)
- Parent-Child Interaction Therapy (2-12)

TF-CBT: An Evidence-Based Example

Why TF-CBT?

The vast majority of DCS-involved youth have experienced significant trauma (abuse, neglect, exposure to domestic violence, etc.)

Trauma-informed care is a “core competency” in working with DCS-involved youth

TF-CBT (Cont.)

Appropriate candidates for this program include:

- Children and adolescents with a history of sexual abuse who:
  - Experience PTSD
  - Show clinically significant levels of depression, anxiety, shame, or other dysfunctional abuse-related feelings, thoughts, or developing beliefs
  - Demonstrate behavioral problems, especially age-inappropriate sexual behaviors
- Children and adolescents who have been exposed to other childhood traumas (e.g., exposure to domestic violence, traumatic loss of a loved one)
- Non-offending parents (or caregivers) of the victims of sexual abuse or trauma

TF-CBT (Cont.)

Generally, the goals of TF-CBT are to:

- Reduce children's negative emotional and behavioral responses to the trauma
- Correct maladaptive or unhelpful beliefs and attributions related to the traumatic experience (e.g., a belief that the child is responsible for the abuse)
- Provide support and skills to help non-offending parents cope effectively with their own emotional distress
- Provide non-offending parents with skills to respond optimally to and support their children
- Create a trauma narrative

TF-CBT (Cont.)

What are the outcomes?

- TF-CBT reduces symptoms of PTSD, as well as symptoms of depression and behavioral difficulties in children who have experienced trauma.
- Compared to other tested models and services, TF-CBT resulted in greater gains in fewer clinical sessions. Follow-up studies have shown that these gains are sustained over time.
- Studies reveal that more than 80 percent of children show marked improvement in symptoms within 12 to 16 sessions (using one 60- to 90-minute session per week).
- Research also demonstrates a positive treatment response for parents. In TF-CBT studies, parents often report reduced depression, emotional distress associated with the child's trauma, and PTSD symptoms. They also report an enhanced ability to support their children.

Evidence Based?

TF-CBT (Cont.)

- Free web-based training can be obtained through the Medical University of South Carolina at www.musc.edu/tfcbt
- Free resources for implementing TF-CBT can be obtained at www.NCTSN.org
- For on-site TF-CBT training, contact:

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Next Steps: DCS Evidence-Based Initiatives

- Create a trauma-informed system of care
- Screen all children entering the system for trauma
- Fund training, implementation and fidelity costs for a select group of evidence-based practices (i.e., those that best meet the needs of DCS youth and families)
- Contract with providers to establish a continuum of evidence-based services statewide
- Develop systems and processes to ensure appropriate utilization of psychotropic medications
- Create data systems to allow for aggregation and analysis of relevant process, outcome and satisfaction data

Avoid System-Induced Trauma……

Trauma-Informed System of Care (NCTSN)

1. routinely screen for trauma
2. use culturally appropriate evidence-based assessment and treatment
3. make resources available to children, families, and providers on trauma exposure, its impact, and treatment
4. engage in efforts to strengthen resilience and protective factors
5. address parent and caregiver trauma and its impact on the family system
6. emphasize continuity of care and collaboration across child-service systems
7. address, minimize, and treat secondary traumatic stress among DCS employees

Screening for Trauma

- Utilize trauma response item from the CANS
- Develop a trauma-specific CANS module
- Develop a standardized trauma assessment service standard
- Provide training to FCMs

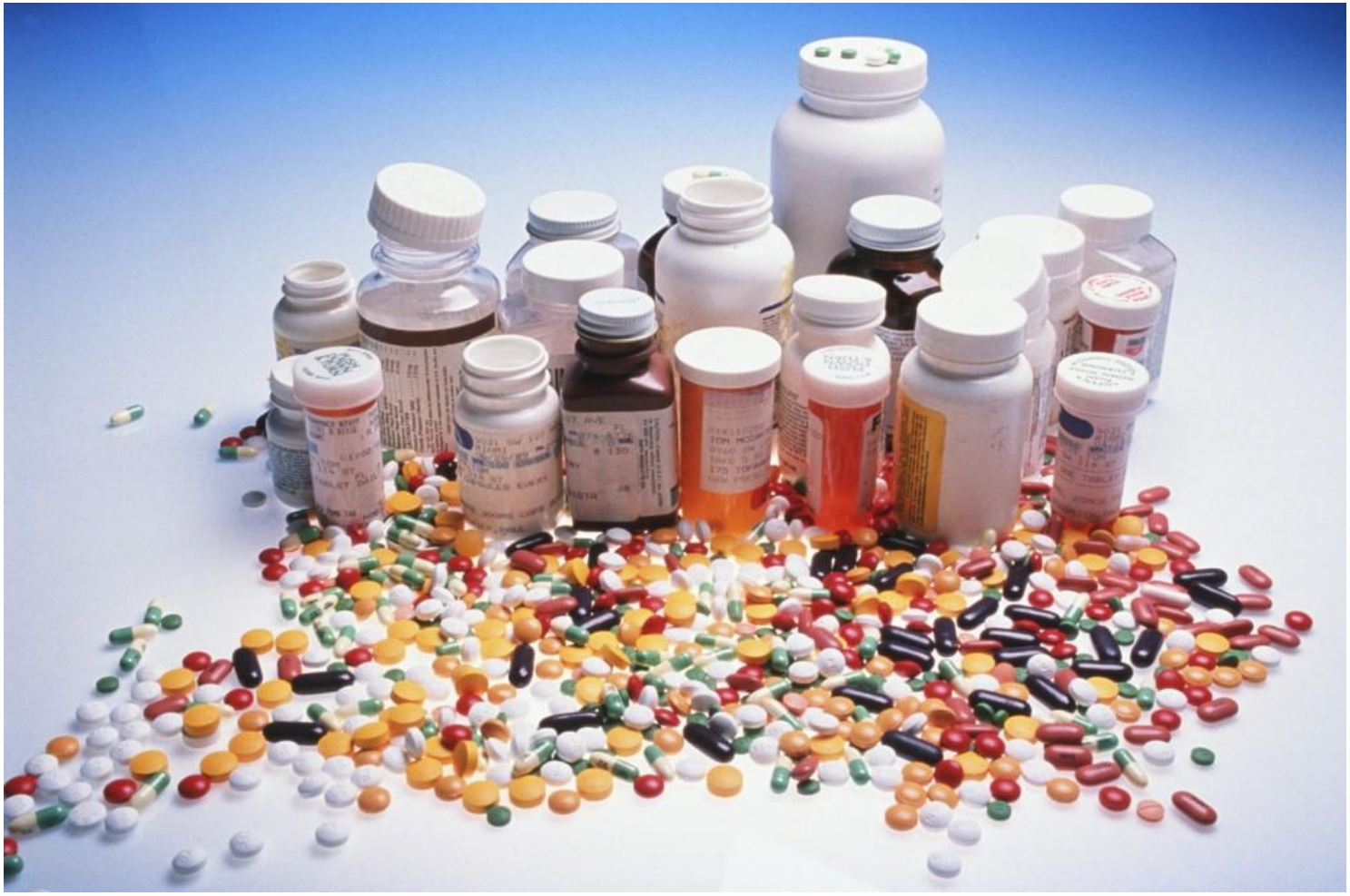
DCS Funding for EBP

- Funds have been allocated to assist providers in building the capacity to utilize EBPs
- DCS will be choosing several EBPs to support
- For chosen models, DCS will provide training and quality assurance to ensure fidelity to the model
- Chosen models will be announced by 11/1.

Contract with Providers for EBP

- DCS currently contracts for the following EBPs: Homebuilders, Functional Family Therapy, Multisystemic Therapy, Health Families
- DCS residential contracts require the adoption of TF-CBT as a "core competency"
- DCS has released an RFP for Comprehensive Community Based Services (requires use of EBP)

What about Psychotropic Medication?



Psychotropic Medication Use among Youth in State Care: Disturbing Trends

- Youth in state care are prescribed psychotropic medications at rates that are significantly higher than comparable youth who live at home
- Youth in state care are more likely to be prescribed multiple psychotropic medications (too many)
- Youth in state care are more likely to be prescribed psychotropic medications at dosage levels that exceed recommendations (too much)
- Youth in state care are more likely to be prescribed psychotropic medications at younger ages (too young)
- Youth in the most restrictive placements are more likely to be prescribed multiple psychotropic medications

Psychotropic Medication Oversight: Statutory Mandates

- **Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351)** – requires oversight of prescription medications for children in foster care

- **The Child and Family Services Improvement and Innovation Act of 2011 (PL 112-34)** – state plans must include protocols for the appropriate use and monitoring of psychotropic medications

Indiana Psychotropic Medication Initiative (DCS, OMPP, DMHA, IUSM)

- **Assessment** – implement statewide mental health screening and assessment protocols
- **Monitoring** – establish data reporting processes and formats
- **Consultation** – establish consultation protocols with IU Department of Psychiatry (EBP from AACAP)
- **Oversight** – establish Psychotropic Medication Advisory Committee
- **Education** – establish psychotropic medication information portal
- **Training** – establish comprehensive training program for providers, consumers and DCS field staff

Need Direction?

Evidence-Based Program Resources

- The National Child Traumatic Stress Network (www.NCTSN.org) – Provides resources and guidelines for understanding traumatic stress and developing programs.
- Evidence-Based Practices Website (Developed by the National Association of State Mental Health Program Directors Research Institute) (www.nri-inc.org/CMHQA.cfm) – Describes what different States are doing regarding EBPs
- SAMHSA's Guide to Evidence-Based Practices (EBP) on the Web (www.samhsa.gov/ebpwebguide/index.asp) - Provides a list of Web sites with information about specific EBPs or reviews of research findings.
- Choosing the Right Treatment: What Families Need to Know About Evidence-Based Practices (www.nami.org) – Provides information for families about evidence-based treatment.

Evidence-Based Program Resources

- Therapy Advisor: Promoting Scientifically-Based Psychotherapy (www.therapyadvisor.org) – Provides information for consumers and providers on effective psychosocial treatments.
- The California Child Welfare Clearinghouse for Evidence-Based Practice (www.cebc4cw.org) - Search engine included.) Covers adult, child, geriatric, chemical dependency and health behavior therapies.
- The Child Welfare Information Gateway (http://www.childwelfare.gov) – Provides information, resources and links RE: Child Welfare programs.
- The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) (www.tapartnership.org) – provides assistance in moving system initiatives forward.

Definitely Evidence Based!

Have questions about evidence-based practice?

For additional information about evidence-based practices, feel free to contact me at:

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Thank You, James W. Payne!